WORLD RELIEF CORPORATION (WRC)/ CHRISTIAN SERVICE SOCIETY BANGLADESH CHILD SURVIVAL X PROJECT

KHULNA, BANGLADESH

MID-TERM EVALUATION

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World Relief

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TABLE OF CONTENTS

I. Accomplishments 3

II. Effectiveness ..... .

III. Relevance to Development 13

IV. Design and Implementation 13
- IV.A Design 13
- 1V.B Management and Use of Data 13
- 1v.c Community Education and Social Promotion 14
- 1V.D Human Resources for Child Survival 16
- IV.E Supplies and Materials for Local Staff 19
- IV.F Quality 19
- 1V.G Supervision and Monitoring 20
- IV.H Regional and Headquarters Support 21
- IV.1 PVO's Use of Technical Support. 21
- 1V.J Assessment of Counterpart Relationships 23
- 1V.K Referral Relationships 25
- 1V.L PVO/NGONetworking 25
- 1V.M Budget Management 25

V. Sustainability 26

VI. Recommendations 28

VII. Summary 32

APPENDICES

ACRONYMS

ALRI	Acute Lower Respiratory Infection
BNNC	Bangladesh National Nutrition Council
CDD	Control of Diarrheal Disease
CHW	Community Health Worker
c s s	Christian Service Society
EOP	End of Project
EPI	Expanded Program for Immunizations
FPAB	Family Planning Assistance Bangladesh
FWV	Family Welfare Visitor
GM	Growth Monitoring
HA	Health Assistant
IG	Income Generation
SK	Shishu Kabar
UCEP	Underprivileged Children's Education Project
VHSS	Voluntary Health Services Society

L Accomplishments

At the time of the evaluation, the Project had been in operation for 20 months (October 1994 through May 1996). Fifty-five percent (55%) of the time allotted to the project has elapsed. In general, it is clear that the project is on wurse at midterm. Details of its progress are described in this report, and recommendations for modification of objectives and activities are made.

Some highlights of the project's accomplishments include a very comprehensive and well-monitored system of data collection to track progress of the project and maintain close supervision of a rather large (103) contingent of community health workers (CHWs). Training has been a prime focus of project activity. Monthly educational meetings for area coordinators and supervisors have been conducted regularly. The supervisors in turn conduct monthly training for the CI-IWs at the subcenter offices in each area. Supervisors visit CHWs to check their registers and make sure they are giving the correct messages. Training has been done for five of the six project interventions: (1) Expanded Program for Immunization (EPI), (2) Control of Diarrheal Disease (CDD), (3) Nutritional Improvement, (4) Maternal Care and Family Planning, and (5) Income Generation (IG). These have been taught and phased in over the life of the project. Management of acute lower respiratory infections (ALRI), the last project intervention, is due to be phased in shortly.

The nutrition demonstration and rehabilitation component of the project is patterned after the Hearth or Foyer program pioneered by Drs. Warren and Gretchen Berggren. In Bangladesh this program is called Shishu Kabar (SK) and features the use of local foods, prepared by mothers themselves in their own community. SK trainers have been trained to work with mothers and have established mechanisms for selecting children for rehabilitation and follow-up growth monitoring. The data to be obtained from this should provide an excellent evaluation of the SK approach to rehabilitation by the end of project (EOP). A special report on this component of the project is included in Appendix B.

The project does not deliver immunization services but does track children to encourage timely vaccination at the government EPI assembly posts. This has resulted in excellent coverage rates for children. Rates of TT2 coverage for women (15-45) are not as satisfactory, in part perhaps, because the emphasis in Bangladesh has been on immunizing pregnant women, and the objective is written for all women aged 15 to 45. An additional complication arises in that many women who have had TT2 in past years when they were pregnant have since lost their cards and are not easily motivated to get additional vaccinations since they associate the need for vaccination with pregnancy.

A form of folk song known as **Jari** is popular and seems to be quite an encouragement to the **CHWs**. About 300 people show up to a **Jari** session, the entertainment welcomed as a respite from the round of seemingly endless work. The **Jari** is advertised in the local market, and the **CHWs** also let people know it is coming. Sometimes they are able to advertise through the government drum-beater, which is very attention catching. The Jatra (traditional theater) program was begun, but proved to be too controversial, particularly in the more traditional areas of the project.

Child spacing appears to have been very successful in this project area. This parallels trends in Bangladesh as a whole where modem contraceptive use has increased dramatically over the past decade **(DHS** Survey, 1994). Project staff and **CHWs** received family planning training in January and February 1996. **CHWs** follow up on women who have started using contraception to prevent dropout. At the CHW home visit, the mother is asked which method she is using and whether she is having any trouble with it. **CHWs** do not distribute contraceptives. Mothers go to the MOH subcenter or receive supplies from an MOH Family Welfare Visitor **(FWV)** who does home visits. Access to contraceptives seemed adequate in the project area. FWVs also attend some **EPI/GMC** meetings to promote and provide contraception.

The original project objectives, planned inputs and outputs by intervention are shown in Table 1 below. Each input and output listed in Table 1 is followed by a status code to indicate the degree to which it has been delivered. **(D =** delivered as planned to mid-term; Q+ = positive indications based on a qualitative assessment; NM = not measured where the method of measurement is the EOP KPC; Q- = negative indications based on qualitative assessment; ND = not delivered or substantially less than planned.) Explanatory notes, numbered to correspond to the superscript numbers accompanying the status codes of each input or output, are found at the end of each page of the table.

Table 2 in Section II restates the objectives and provides an assessment of the degree to which they have been achieved.

Table 3 in Section II provides a summary of the outcomes of the nutrition rehabilitation program known as the "Shishu **Kabar"** (SK).

D = Defined as planned
Q- = Negative indicators
Q+ = Positive

Table 1
Delivery of Inputs and Outputs

Project Objective	Major Planned Inputs	status	Outputs	status	Measurement Method
1. Increase from 65% to 90% the number of children 12-23 months completely immunized	1. Train CHWs to educate mothers 2. Follow-up of defaulters 3. Hold educational mothers group meetings	1. D 2. D 3. Q-'	1. Mothers' knowledge improved 2. Increased number of children vaccinated 3. Decreased drop-out rate	1. Q+ 2. D 3. D	1. KPCsurvey 2. Bimonthly check of MOHFP EPI cards on home visits 3. Same as 1 and 2 above
2. Increase from 48% to 80% the number of women 15-45 years receiving at least 2 doses of tetanus toxoid (TT2)	1. Train CHWs and TBAs to educate fertile-aged women 2. Follow-up of defaulters 3. Hold educatmnal mothers group meetings	1. D 2. Q-[2] 3. Q-[1]	1. Knowledge of fertile-aged women improved 2. Increased number ofwomen vaccinated 3. Decrease in missed &ties and dropout	1. Q+ 2. D 3. D[4]	1. KPC Survey 2. Bimonthly check of MOHFP TT cards on home visits 3. Same as 1 and 2 above
3. Increased from 64% to 75% the number of children exclusively breast-fed until 4 months	1. Tram CHWs and TBAs for education and promotion activities 2. Folk theater 3. Hold educational mothers meetings	1. D 2. Q+[3] 3. Q-'	1. Improved knowledge of mothers 2. Increased number of mothers exclusively breast-feeding until 4 months	1. Q+ 2. NM	1. KPCsurvey
4. Increase from 0.1% to 70% the number of children O-23 months weighed bimonthly	1. Supervisors and CI-lWs trained to weigh children 2. Promote and conduct growth monitoring sessions 3.Give food demonstrations and nutrition counseling	1. D 2. D 3. D	1. Increase the number of children weighed every 2 months	1. D	1. KPCsurvey 2. Bimonthly check of Bangladesh National Nutrition Council (BNNC) growth chart

1. Mothers group meetings were held occasionally but not on a regular basis. There has been some resistance to this in more traditional communities.
2. Attempts have been made in some places to follow up defaulting women, but this has been limited to pregnant women for the most part.
3. Traditional theater has been replaced by the use of a troupe of folk singers, which appears to be quite popular.
4. The number of women completing TT2 remains below the objective, suggesting that the drop-out rate is still too high.

Project Objectives	Major Planned Inputs	Status	outputs	Status	Measurement Method
5. Increase from 0 to 60% the number of mothers of malnourished children O-23 months attending nutrition demonstrationlrehabilitation	1. Train volunteer mothers 2. Organize 2 weeks of nutrition rehabilitation demonstrations sessions (Hearth sessions)	1. D 2. D	1. Increase in percentage of malnourished children who have catch up or adequate growth	1. NM[2]	1. Follow-up weighing of children at 1 month and 2 months after attending Hearth sessions
6. Increase from 0.7%to 60% the number of children O-23 months whose mothers knew to introduce calorie-dense foods	1. Train CHWs to conduct monthly mothers educational sessions 2. Conduct food demonstrations	1. D 2. D	1. Increase knowledge of mothers 2. Increase in percentage of mothers who feed caloriedense food to their children	1. Q+ 2. NM	1. KPC Survey
7. Increase from 45% to 80% the number of children 12-7 1 months receiving 2 doses of Vitamin A annually	1. Train CHWs 2. Hold monthly mothers groups 3. Assist MOHFP in mass distribution campaigns 4. Refer defaulters and those needing treatment	1. D 2. Q-[1] 3. D 4. D	1. Increase in percentage of children with 2 prophylactic doses of Vitamin A each year	1. D	1. KPC Survey 2. Bimonthly check of MOHFP EPI cards and BNNC growth&arts
8. Increase from 2% to 75% the number of mothers receiving 200,000 I.U. Vitamin A in the first month post-partum	1. Train TBAs to administer Vitamin A 2. Train CHWs to educate the mothers	1. D 2. D	1. Increase in percentage of mothers who receive Vitamin A post-partum 2. Increase in mothers' knowledge of need for post-partum Vitamin A	1. D 2. NM	1. KPC Survey 2. Bimonthly check of MOHFP TT cards
9. Increase from 47% to 70% the number of women 15-45 who have access to kitchen gardens with Vitamin A-rich foods	1. Train CHWs to educate mothers 2. Conduct educational sessions 3. Provide seeds (CSS funding) 4. Conduct food demonstrations	1. D 2. D 3. D[3]	1. Increase in percentage of mothers who have access to kitchen gardens 2. Increase in the number of Vitamin A-rich foods in the gardens 3. Increase in the home use of foods from the kitchen gardens	1. D 2. NM 3. NM	CSP census years 1, 2 & 3

1. Occasional mothers group meetings were held, but these were not done monthly and were generally not well attended.
2. The ongoing study of the Shishu Kabar program to rehabilitate malnourished children is collecting data to confirm or negate this output. As yet, data is inconclusive.
3. A nursery has been established at the CSS Center in Paikgacha, from which seedlings are distributed to clients. No quantitative estimate can be made.

Project Objectives	Major Planned Inputs	Status	Outputs	Status	Measurement Method
10. Increase from 66% to 80% the number of mothers of children 0-2 months who administer ORT for diarrhea	1. Tram CHWs 2. Hold mothers group meetings 3. ORT demonstrations 4. Distribute ORS 5. JATRA folk theater	1. D 2. Q- [1] 3. D 4. D 5. D [2]	1. Increase in ORT use 2. Increase in home availability of ORS 3. Increase in mothers' knowledge	1. Q+ 2. NM 3. NM	1 and 4. KPC Survey 2 and 3. Bimonthly visit to home to see if ORS is available and mother can prepare
11. Increase from 16% to 50% the number of mothers of children O-23 months who continue feeding during diarrhea	1. Train CHWs 2. Hold mothers educational group meetings	1. D 2. Q- [1]	1. Increase in feeding during diarrhea	1. NM'	1. KPC Survey
12. Increase from 28% to 60% the number of mothers of children O-23 months who know the signs of dehydration	1. Train CHWs 2. Hold mothers educational group meetings	1. D 2. Q-	1. Increase in mothers' knowledge	1. Q+	1. KPC survey
13. Increase from 35% to 50% the number of mothers who recognize pneumonia and receive appropriate treatment	1. Train CHWs 2. Train MOHFP staff to give appropriate treatment and handle referrals 3. Mothers group meetings 4. JATRA folk theater	1. ND' 2. ND' 3. ND' 4. ND'	1. Increase in percentage of mothers who recognize pneumonia and seek help 2. Increase in percentage of doctors who follow the WHO algorithm	1. NM' 2. NM'	1. Bimonthly home visit 2. Use of referral/counter referral slips

1. Occasional mothers group meetings have been held, but these have not been regular nor well attended.
2. Folk songs or "Jar-i" have been used rather than folk theater, which was tried but not as well received.
3. Feeding practices during diarrhea will be assessed with the KPC survey, but informal interviews suggest that while breast-feeding may be continued, the child's loss of appetite limits the amount of food consumed even though it is offered.
4. The ALRI intervention had not been initiated by midterm. It is scheduled to be introduced immediately after the evaluation.

Project Objectives	Major Planned Inputs	Status	Outputs	Status	Measurement Method
14. Increase from 11% to 50% the number of pregnant women consulting trained provider for antenatal care	1. TrainTBAs 2. Train CHWs 3. Hold mothers educational group meetings 4. JATRA theater	1. D 2. D 3. Q-' 4. D[2]	1. Increase in # of trained TBAs 2. Increase in referral of high risk pregnancies to MOHFP facilities 3. Increase in percent of women receiving prenatal care	. D 2. Q-[3] 3. D	1. Attendancerecordsof TBA training sessions 2. HIS and referral/counter-referral slips 3. Bimonthly check of MOHFP prenatal care card
15. Increase from 32% to 45% the number of eligible couples using modern methods of contraception	1. Tram CHWs 2. Followupon womenusing contraception to prevent dropout 3. Collaborate with MOHFP FWVs including them in EPI/GMC	1. D 2. D 3. Q-[4] 4. Q-'	1. Increased knowledge of women 2. Increased contraceptive prevalence	1. NM 2. D	1. KPC survey 2. KPC survey and bimonthly home visit.
16. Increase from 14% to 35% the number of pregnant women who eat more than usual	1. TrainTBAs 2. TrainCHWs 3. Hold mothers educational group meetings 4. JATRA theater 5. Weigh pregnant women	1. D 2. D 3. Q-' 4. D 5. ND'	1. Increased knowledge of mothers 2. Increase % of women who eat more during pregnancy 3. Increase in % of women gaining weight	1. NM 2. NM 3. NM'	1 and 2. KPC survey 3. Bimonthly check of MOHFP antenatal care card
17. 50% of mothers of children O-23 months who participate in at least one "JATRA" on child survival	1. Purchase equipment for JATRA 2. Write script with JATRA troupe 3. Mobilize community to participate in JATRA	1. D[2] 2. D[2] 3. D[2] 4. D[2]	1. Community members including mothers to participate in JATRA 2. Community members including mothers attending JATRA	1. D[2] 2. D[2]	1. List of participants 2. Home visits asking mothers ifthey attended a previous JATRA performance

1, Occasional mothers group meetings were held, but these were not regular nor well attended.

2. Folk songs or "Jari" have been used rather than folk theater, which was tried but was not as well received.

3. Referrals are discussed in Section XX Remoteness of many communities, less than adequate communication between project-trained TBAs and government workers, and inadequate facilities have made delivery of this output extraordinarily diflicult.

4. There has been an attempt to include FWVs in the EPI/GMC assembly posts in some communities, but more communication between project staff and government maternal care providers needs to be developed.

5. No appropriate scales have been available for weighing women. CSS staff will approach UNICEF for this type of scale.

IL **Effectiveness**

Progress toward meeting stated objectives and targets is portrayed in Table 2 below. Overall progress is very satisfactory. TT2 coverage for all women in the 15 to 45 age group appears to be low, but this is true generally in Bangladesh where emphasis has been on immunizing pregnant women although policy included all CBA women. Actual service delivery to achieve immunization coverage, Vitamin **A** distribution and antenatal care has been the responsibility of government personnel, with CS project staff promoting these services and tracking dropouts. Growth monitoring, nutrition counseling and the demonstration/rehabilitation program known as Shishu Kabar (SK) is a service delivered by the Shishu Kabar Trainers, part of the CS project staff. This intervention appears to have achieved its objectives, but data on the outcomes of the SK program are preliminary and inconclusive at this point. These preliminary data are presented in Table 3 and in Dr. Gretchen Berggren's report on the program in Appendix B.

BASICS has sponsored a Technical Advisory Group on HEARTH that met in Wheaton, Illinois, at WRC HQ. Representatives from HEARTH projects in Haiti, Viet Nam and Bangladesh attended and discussed the methodology and effectiveness of the programs. One outcome has been the development of an evaluation plan for Shishu Kabar, developed with assistance by Laura Caulfield of JHU, a specialist in nutritional epidemiology. World Relief is presently involved in implementing that evaluation plan and inputting data from GMC sessions on Shishu Kabar and non-Shishu Kabar children under the age of two. Data from this evaluation should be available by the final evaluation of the project next year.

Table 2: Objectives and Achievements

Objective	Year 2 Target	Midterm Achievement	Method of Measurement
1. Children 12-23 months completely immunized by 12 months	**80%**	**Oct/Nov 2,644/2,735 = 96.7%** **Dec/Jan 2,592/2,889** = 89.7% **Feb/Mar 2,637/2,762** = 95.5%	Household register & **CHW** reports
2. Women 15-45 receiving at least 2 doses of tetanus toxoid (TT2)	**70%**	**Oct/Nov 11,440/27,875** = 41.0% **Dec/Jan 13,044/27,801** = 46.9% **Feb/Mar 13,915/27,345** = 49.6%	Household register & CHW reports
3. Women exclusively breast-feeding until 4 months	**70%**	To be measured by KPC survey at final evaluation	
4. Children O-23 months weighed bimonthly in village GMC sessions	**60%**	**Oct/Nov 3,528/6,055 = 58.3%** **Dec/Jan 3,570/5,907** = 60.4% **Feb/Mar 3,675/5,853** = 62.7%	Household register & CHW reports

Objective	Year 2 Target	Midterm Achievement	Method of Measurement
5. Mothers of malnourished children 0-23 months attending hearth nutrition demonstration & rehabilitation sessions	50%	0[12]	
6. Mothers of children 0-23 months who know to introduce calorie dense foods	50%	To be measured by KPC survey at final evaluation. Qualitative interviews suggest satisfactory progress.	
7. Children 12-71 months receiving 2 prophylactic doses of Vitamin A annually	70%	Oct/Nov 13,288/14,597 = **91.0%**	Household register & CHW reports
8. Mothers receiving 200,000 IU Vitamin A in the first month postpartum	55	Feb/Mar 190/338 = **56.2%**	Household register & CHW reports
9. Mothers who have access to kitchen gardens with Vitamin A-rich foods	60%	Dec/Jan 18,346/27,805 = **66.0%** Feb/Mar 17,812/27,345 = **65.1%**	Household register & CHW reports
10. Mothers of children 0-23 months who administer ORT for diarrhea	75%	To be measured by KPC survey at final evaluation. Qualitative interviews suggest this is a widespread practice.	
11. Mothers of children 0-23 months who continue feeding during diarrhea	40%	To be measured by KPC survey at final evaluation. Qualitative interviews suggest breast-feeding is continued but loss of appetite limits other food intake.	
12. Mothers of children 0-23 months who know the signs of dehydration	50%	To be measured by KPC survey at final evaluation. Qualitative interviews suggest some progress.	

'The numerator for Objective 5 k the total number of malnourished children (1038) whose mothers have completed the nutrition rehabilitation/demonstration sessions since they began in August 1995.

[2]The denominator (2284) k estimated using an average of the bimonthly prevalence of malnutrition among those children who were weighed In growth monitoring sessions then extrapokting to the entire populatii of O-23 month-olds, assuming that the nutritiil status of the popuktion not weighed k the same as that of the children who were weighed.

Objective	Year 2 Target	Midterm Achievement	Method of Measurement
13. Mothers of children O-23 months who recognize pneumonia and receive appropriate treatment	-	This intervention had not yet **been** initiated.	
14. Pregnant women consulting a trained provider for antenatal care	35%	**Oct/Nov 782/1,363** = 57.3% **Dec/Jan 798/1**. 192 = 66.9% **Feb/Mar 781/1,112** = 70.2%	Household register & **CHW** reports
15. Eligible couples using modern methods of contraception	40%	**Oct/Nov 12,612/24,406** = 51.7% **Dec/Jan** 13,5 **12/23,995** = 56.3% **Feb/Mar 13,993/24,333** = 57.7%	Household register **&** CHW reports
16. Pregnant women who eat more than usual during pregnancy and lactation	25%	To be measured by KPC survey at **final** evaluation. Qualitative interviews suggest this is not widely acceptable as yet.	

Table 3

Results of "Shishu Kabar" Program (CSS) Paikgacha Service Center Report (August 95-May 96)

union	Total malnourished <23-month-old targeted *	Total enrolled (percent of target)	Total weighed at 1&2 months (percent ofthose enrolled)	Pending--not due for follow-up (percent of those enrolled)	Lost to follow-up or refused weighing (percent of those enrolled)	Results for those weighed (percent of total weighed from column 4)		
						Catch-up growth	Adequate growth	Growth failure
Kapilmuni	249	225 (90.4)	166 (73.8)	35 (15.6)	24 (10.7)	81 (48.8)	74 (44.6)	11 (6.6)
Raruli	230	208 (90.4)	202 (97.1)	0	6 (2.9)	(48076)	115 (56.9)	5 (2.5)
Data for the following Unions are inadequate until more follow-up weighing is done.								
Amadi	320	251 (78.4)	179 (71.3)	42 (16.7)	30 (12.0)	75 (41.9)	96 (53.6)	8 (4.5)
Haridbali	187	167 (89.3)	94 (56.3)	38 (22.8)	$ 9)	70 (74.5)	20 (21.3)	(443)
Godiapur	234	187 (79.9)	128 (68.4)	29 (15.5)	30 (16.0)	35 (27.3)	83 (64.8)	10 (7.8)
TOTAL	1220	1038 (85.1)	769 (74.1)	144 (14.0)	125 (12.0)	343 (44.6)	388 (50.5)	38 (4.9)

* These are children identified as malnourished during growth monitoring, in which approximately 60% of all children in this age group participate.

Note: The above table needs to be revised and all figures recalculated after the "pending" weighing is complete and after a real effort has been made to obtain values for parents who refuse to have their children weighed. Apparently the refusal has to do with mothers-in-law who feel that the baby's crying when weighed has an adverse effect. In this case, just as stated in the DIP, it is imperative that education be done with fathers and grandmothers so that they will agree to weigh the child one more time.

III. Relevance to Development

This project enhances and extends government efforts to provide community level health services to the people in its impact area. Its focus on social mobilization has helped the government's EPI program to increase immunization coverage, for example. The project's training of TBAs improves access to antenatal care for a population of women who have access to very limited resources. Government workers such as the health assistants, family welfare assistants and family welfare visitors are responsible for areas which are much too large for them to serve adequately. With the assistance of project supervisors and CHWs, government workers are much better able to reach the communities under their care.

CSS also has a very active Ladies Savings and Loan Society (Income Generation Project) in this area. A line in the CS budget contributes to this loan fund, adding to the ongoing program of the CSS Center in Paikgacha. This activity has been a central part of the CSS mission since its inception in the early 70s, giving the organization considerable expertise in this business. There is a close tie between CS loans and nutrition rehabilitation (Shishu Kabar) activities. Mothers selected for loans are those whose children have not responded to the Shishu Kabar program with adequate growth. Such selection is based on the assumption that the family's resources are inadequate to provide the nutrients needed in spite of wise food selection and appropriate preparation learned in demonstration sessions.

There has been no direct collaboration with other NGOs or government agencies other than the MOHFP. Communication with other NGOs is maintained through the Khulna VHSS network in which CSS is active.

Iv. Design and Implementation

IV.A Design

There has been no change in the project area since the DIP was submitted. The relatively stable impact population is tracked as closely as possible through household registers maintained by CHWs.

IV.B Management and Use of Data

Data in the health information system follow the supervision channel which is provided through vertical "chains of command." Information originates with the CHWs household registers, which are reported to the supervisors who prepare summary reports for the union officers. Union officers, in turn, summarize the reports of supervisors, and these summaries are sent to area coordinators who submit bimonthly reports to the project director. TBAs report births, antenatal visits and high-risk pregnancies to nurse-midwife trainers who report to the area

coordinator. Five SK trainers report their activities and follow-up data on the growth of children in the program to the SK program coordinator who reports to the project director.

The data for the SK program are of particular interest. This innovative program is potentially sustainable with local resources. If demonstrated to be effective, it can become a model for widespread application. A more detailed report on the program, prepared by Dr. Gretchen Berggren, is included in Appendix B. Her comments which depict some practical issues in data collection follow:

> These data are well kept and useful, but are being hampered by the lack of follow-up of some of the children who attended the SK sessions, leading to too many missing values in the tables. There is a misunderstanding that if the child is not found and weighed exactly at his/her "one-month anniversary" or "two-month anniversary" of entry to the SK program, it is not worth doing. Instead, it is crucial that the child is found and weighed as soon as possible after these anniversary dates. What is needed is the birth month/year for each child followed by date/weight. The weights can then be graphed, and it will be easy to see whether the child is growing as fast or faster than the international standard median weight for age. Length measurements were taken at the beginning of the SK program much to the resentment of the mothers who found that children cried even more when being held to be measured than when being weighed. Although it is my understanding that Lisa Filoramo of World Relief, who helped initiate the program, suggested that length measurements be dropped, the project has kept on trying to get them despite the objection of mothers. In one impact area (Haridhali) the mothers have blamed their children's subsequent illnesses on the fact that their children cried so much during the length measurement.

Data collected is forwarded up the organizational ladder to the CSS office in Khulna and WRC HQ. Staff above the level of supervisors are quite well informed of overall project performance. Supervisors are very aware of what is happening in their own wards, but CHWs are not well informed of what progress is being made, nor is there an established mechanism for reporting to community members. Data sharing with counterpart government agencies has taken place occasionally but has not been a regular practice. Data on the SK program and its outcomes are being collected and, when sufficient, will be analyzed and disseminated through PVO forums and public health and nutrition literature. This system of data collection has been incorporated in other WRC projects and benefits from the experience of other PVOs. The system is well documented in the DIP and other WRC reports.

IV.C Community Education and Social Promotion

Social mobilization began well before health service or promotion in this project area. First of all, there was a demand on the part of local leaders for CSS child survival activities to expand to Paikgacha geographic areas based on the perception that CSS already had established successful child survival programs. Secondly, project strategy has been to meet a felt need on the part of

the community, that of income generation. Leaders had already been identified and had expressed a wish for health activities. Social mobilization activities begun in 1994 were intensified as soon as CSS was notified that it had received funds for a child survival grant for the area.

The best material evidence of social mobilization is the building constructed by a family in the Paikgacha area to provide project office space and housing. The three-story structure will eventually also serve as an eye hospital and possibly temporarily as a maternal health center for obstetric emergencies. It could also be used as headquarters for disaster response in the event of a cyclone, as it is one of the only well-built and solid stuctures for miles around.

Health service provision works in concert with government health infrastructure, with government personnel providing direct services and CSS workers promoting service utilization, mobilizing the community, and following up in such cases as immunization dropouts. The government does not have enough volunteer community health workers (1:250 families) or supervisors for this category. This cooperative arrangement includes the EPI program in which government health assistants provide immunization service, and CSS workers do promotion and follow-up. Similarly, project staffpromote Vitamin A and family planning while government workers provide the actual services.

Income generation activities account for approximately 20% of the budget and are a highly valued service in the communities of the project area. This activity is the largest element of service delivery within the project.

Health messages were largely tested in the old project area and refined by the project director. Messages used are similar to MOH messages. Community education has relied heavily on home visits by CHWs to communicate most health messages. Home visits work best in Bangaldesh because women are confined to their homes through the practice of "purdah" or seclusion. Women do not even do the market shopping, and rarely travel farther than the fields they work in daily. Home visits are the only way to reach a majority of the women.

Additionally, EPI posts conducted by government workers include a growth monitoring station which provides nutrition counseling and selection and referral to the SK program. The SK program (see Dr. Gretchen Berggren's report in Appendix B) is a program in which mothers participate in rehabilitating their malnourished children using local foods in the setting of their own communities. This event is an intense learning experience.

The level of learning is assessed regularly by supervisors' visits to mothers, in which they use a checklist to see what messages have been learned and what practices adopted. Where discrepancies are found between the mothers' knowledge and the messages of the project, CHWs are counseled by the supervisors. Informal interviews by the evaluation team suggest that the CHWs are indeed actively communicating the health messages as planned. A more quantitative assessment of this learning will be done through a final KPC survey at the end of project evaluation.

Health education materials seem to be quite scarce. The health educator can get only 5 copies of any government produced poster or brochure which he uses in educational sessions and gives to area coordinators for training CHWs. CHWs, in turn, use them in mothers group meetings. The project does not have funds to develop printed materials, which are very scarce in Bangladesh as a whole. By networking with other PVOs, the health educator is able to get some new materials, but not in abundance.

The project's approach to community education is "no child is left out," and it is therefore committed to census-based HIS and home visits by trained and supervised CHWs. Community members are consulted before a project starts, and for this reason CSS has good relationships with the local MOH and health staff. Jari programs developed to present health messages for each intervention get an audience of 300 people per session on average.

IV.D Human Resources for Child Survival

Oversight of the project is done by the managing director of CSS in Khulna, who carefully monitors project finances, staffing and activities. The project is staffed by a project director (a physician); an office-based staff consisting of the area coordinator, health educator, accountants (shared with CSS loan program), a Shishu Kabar coordinator, and two maternal health trainers; five union officers, each overseeing three supervisors, who in turn supervise seven or eight community health workers.

The two maternal health trainers, who are trained nurses, supervise the TBAs. This is a less intense supervision aimed more at providing first-level referral for suspected high-risk pregnancy and ongoing TBA training. There is some evidence that TBAs were not chosen as planned (that is, that they should be identified by the community as already active). TBAs may instead have been political choices (as in one instance where the woman trained had never delivered babies and is not a native resident, but is a relative of the local CARITAS employee). Now that the project is reporting births, they could be reported by name of attendant, and a simple frequency tabulation used to identify the most active TBAs for future training.

The SK coordinator supervises five SK trainers, assisting them with their initial SK sessions, collecting data on SK outcomes, and providing ongoing support. There was strong technical assistance to the SK program for nine months while Lisa Filoramo from WRC headquarters worked with the project as a nutrition advisor setting up the Shishu Kabar program. Technical assistance from Dr. Gretchen Berggren in designing the program and at the midterm evaluation visit has provided guidance as well. However, this research-oriented component of the project would benefit from ongoing professional oversight and supervision. Laura Caulfield, Ph.D., a nutrition epidemiologist from Johns Hopkins, has provided technical assistance in developing an evaluation plan for HEARTH, which is being implemented in the field.

The above mentioned personnel are paid staff including the CHWs, who are given a rather nominal incentive package. The TBAs are paid an even smaller stipend but also receive small fees or payment in-kind from the families of women they attend. CHWs serve as front-line educators and community links for the project. To date 103 CHWs have been trained in project interventions. They give much more than the allotted 10 hours a week to the project, often spending parts of five days a week on home visits and conducting GMC sessions. CHWs interviewed were visiting homes within the bimonthly space of time. All mothers interviewed had CHWs regularly visiting them. On a Lot Quality Assessment in the most inaccessible region (Amadi Union), a CHW was able to identify the mother's name and that she didn't have any children under 5 in the randomly selected house. There appears to be consistent interaction with mothers in the communities that were visited, and CHWs' registers were found to be accurate.

For the most part, the staff are experienced and well trained for their positions. The number of staff is adequate. Consideration can appropriately be given to reducing the number of supervisory personnel as plans for phasing over to a more sustainable staffing level are made (see recommendations). At the community level, where the project has its greatest impact, CHWs are active and aware of the messages they are to deliver. They also do an admirable job of collecting a large body of data. The training activities of the project have been extensive and very well focused on developing the skills needed to perform the tasks.

Table 4

Child Survival Training Program Summary

Type/# Dates	Training Topics	Hours	Trainer(s)	Training methodr
Union Officers (10) supervisors (30) TBA Trainers (5) 10/11/94 to 1 l/14/94 (Half of trainees hired)	Preliminary training, Introduction to CS interventions	80	Project Director	Lecture and discussion
Union Officers (5) supervisors (15) (Monthly)	Refresher and introduction to new interventions	8to 10 hoursfmo	Project Director & Health Educator	Lecture and discussion
Officers and Supervisors Dec. 1994	Data collection for census and the HIS	40 hours	Lisa Filoramo, Project Director	Role play, lecture & discussion
CHWS (103) Jan. 1995	Census-taking and GM for the HIS	16hours	Lisa Filoramo & Supervisors	Role play, lecture & discussion
Interviewers (20) March 9-11.1995	Baseline Survey	24 hours	Dr. F. Rahim, Dr. M. Rahman Lisa Filoramo	Role play, lecture & discussion

Type/# Dates	Training Topics	Hours	Trainer(s)	Training methods
TBAs refresher (Monthly)	Prenatal care, Safe delivery, Diet in pregnancy	8 hrs./mo.	Maternal Health Trainers	Lecture, discussion and demonstration
Jnion Officers (5) supervisors (15) June 16-17, 1995	GMC	24	CSP Health Educator (Dulal Shome)	Lecture, demonstration, Q & A
Jnion Officers (5) Supervisors (15) March 16.19%	GMC (review)	8	Health Educator	Lecture, demonstration, Q & A
SK Trainers (5) luly l-August 3, 1995	Shishu Kabar training	88	WRC Nutrition Advisor (Lisa Filoramo, MSPH) CSP Health Educator	Story, role play, game, slides, pictures, lectures, discussion, Q & A, etc. (Detailed lesson plans available)
SK Trainers (5) March 18-2 1, 1996	Shishu Kabar training	32	Health Educator SK Coordinator, Rabeya Sultana	Story, role play, game, pictures, lectures, discussion, Q & A, etc. (Detailed lesson plans available)
Union Officers (5) supervisors (15) July 26-30, 1995	Nutrition, Vitamin A	16	Health Educator	Story, lecture, posters, vegetables, pictures, Q & A, etc.
Union Officers (5) supervisors (15) August 16-27, 1995	Nutrition, Vitamin A- & iron-rich foods	16	Health Educator	Story, lecture, posters, vegetables, pictures, Q & A., etc.
Union Officers (5) supervisors (15) Sept. 16-21.1995	EPI, &worming	16	Health Educator	Posters, lecture, role play, story, demonstration, Q & A
Union Officers (5) supervisors (15) Oct. 9-22, 1995	EPI, &worming	28	Health Educator	Posters, lecture, role play, story, demonstration, Q & A
Union Officers (5) Supervisors (15) Nov. 20-23, 1995	CDD initial training	24	Health Educator, BRAC consultant (Abubakar Birwan)	Posters, lecture, story, role play, Q & A, practical demonstration
union officers (5) supervisors (15) Dec. 18-26.19%	CDD review	8	Health Educator	Posters, lecture, story, role play. Q & A, practical demonstration
Union Officers (5) supervisors (15) Jan. 13-18, 1996	Mat.Care Family planning	16	Health Educator, 2 Maternal Health Trainers	Posters, lecture, role play, story, Q & A, practical demonstration

Type/# Dates	Training Topics	Hours	Trainer(s)	Training methods
union Officers (5) Supervisors (15) Feb. 34.19%	Mat.Care & Family planning	8	Health Educator, 2 Maternal Health Trainers	Posters, lecture, story, role play, Q & A, practical demonstration
Union Officers (5) Supervisors (15) March 5-13, 1996	GMC	8	Health Educator	Role play, lecture, Demonstration
union Officers (5) supervisors (15) April 2-10.19%	Nutrition, Vitamin A, iron rich foods	8	Health Educator	Lecture, story, posters, Q & A
Union Officers (5) supervisors (15) Jan. 25-27, 1996	SK training (short course)	16	SK Coordinator or Health Educator	Lecture, Q & A
CHWS (103) Nov. 27-30, 1995	CDD (review)	8	Health Educator	Q & A, posters, Role play, practical demonstrations
CHWS (103) Jan 22-2419%	Maternal Care and Family Planning	8	Health Educator, 2 Maternal Health Trainers	Posters, role play, story, lecture, Q & A, practical demonstration
CHWS (103) April 1 l-23,1996	Nutrition, Vitamin A-rich foods, iron-rich foods	8	Health Educator	Story, posters, Q & 4 lecture

IV.E Supplies and Materials for Local Staff

Project vehicles appear to be well maintained and used appropriately. Transport is difficult in much of the project area, mostly by rickshaw van or on foot. The Union officers are equipped with motorcycles. Minimal supplies are required by project design. Food for demonstrations in connection with growth monitoring and the SK program is readily available. Materials for teaching ORT are available in every household. The team suggested that each CHW be provided with these items for teaching demonstrations and that materials be acquired and used for communicating the project's progress to the community.

The TBA delivery kit was an area of some concern. The clean cord-cut kit has no packets with the most important equipment sterilized; instead it consisted of string, cotton, and a new (not sterile) razor blade. The TBA does have instructions to boil this, but until ready to use, the umbilical cord tie may be left loose and soiled. The wrapped and sterilized packets originally recommended for this project have not been adopted, perhaps because sterilization of equipment and supplies is so diicult.

Health education materials seem to be scarce. Also, local health subcenters do not always have enough medicines and antibiotics, so some mothers have to buy these at the market. There seem to be adequate supplies of Vitamin A, vaccines and ORS packets. Contraceptives are also available in good supply. EPI cards are available and can be presented during home visits. All mothers who

were asked were able to produce GMC cards. However, women could not always produce TT cards. Dr. Berggren suggested keeping all health cards together (child's EPI, GMC and mother's card) in the plastic envelope in which they were originally packaged.

IV.F Quality

A baseline survey was conducted to identify levels of knowledge among mothers. Messages were designed to address apparent gaps in knowledge and to achieve progress on the standard child survival indicators. Messages appeared to be clear and project staff well acquainted with them. The evaluation team interviewed individuals from mothers to union officers and found that messages were well disseminated. Supervisors routinely used a checklist of these messages to monitor activities of CHWs and point out deficiencies or lapses. Communication skills seemed quite well developed in SK trainers, who use a very participatory method of teaching mothers to rehabilitate their malnourished children. Among CHWs and other staff the principal communication mode seems to be one of "telling" mothers what they need to know, alhtough in their training, the Health Educator has incorporated Q & A techniques to try to stimulate thinking. Jari folk songs are an exception, as they trigger some active discussion and comment and have the additional benefit of being heard by both men and women.

IV.G Supervision and Monitoring

Section IV.D above outlines the general pattern of supervision. An organization chart is included in Appendix D. Supervision is closely tied to the HIS, which calls for regular reporting of data (bimonthly summaries) and necessitates visits from supervisors to the CHWs who gather information. Supervisors visit ten houses per week. They also make home visits to verify CHW reports and assess the degree to which health messages have been effectively communicated. This is done on a "spot check" basis which may well lead to bias in the selection of homes and CHWs to be checked. The team recommends Lot Quality Assessment Sampling, a more random and scientifically rigorous method of selection for which training will be required. Dr. Warren Berggren is a leader in the field of LQAs, and will be able to provide this training to the staff

There has been strong emphasis on continuous quality improvement. Performance evaluation seems to have been a major part of the supervisory role, but it has been balanced by a good deal of on-the-job education. This has enabled the team to train CHWs to do very good work, particularly in maintaining registers and making home visits. The area coordinator carries primary responsibility for day-to-day supervision and has built a strong supervisory system into the project. All union officers (5) and ward supervisors (15) are men, while all CHWs are women. Men can more easily travel around the wards than women can in this society, but it seems quite possible that a few more progressive women could be found for supervisory roles. Women would be better able to do on-the-job education and could visit homes with CHWs where they would be better accepted by mothers.

Supervisors appeared more likely than other staff to be discontented with pay. In interviews, a few supervisors also pointed out that they are not given sufficient feedback on their performance by the union officers who fill out a supervisory checklist on them for the area coordinator. The team suggests the supervisory checklist be used as a tool for immediate direct feedback to supervisors. More positive feedback to supervisors should especially be encouraged.

The supervisory system of the project closely parallels the government system, though the project is better staffed. Many government positions for HAs and FWAs are not filled. During the remainder of the project, the team suggests, it would be advantageous to transition to a smaller supervisory team and have CHWs work more closely with government workers. This will take substantial effort in communication and collaboration with government workers but should result in a stronger network of health workers in the communities after external funding ends.

IV.H Regional and Headquarters Support

Support to the project headquarters and the regional office has been regularly provided by frequent telephone and fax communications, as well as site visits. Details of site visits are included in Table 5.

IV.1 PVO's Use of Technical Support

Field staffgenerally expressed satisfaction with technical support given to the project. There has been particularly strong technical support for the SK program from Lisa Filoramo, M.S.P.H., a nutrition advisor from WRC headquarters based on-site for nine months to train SK trainers, and Dr. Gretchen Berggren, providing design assistance and additional coaching with the midterm evaluation visit. Locally, training assistance and general guidance are provided by Fazlur Rahim, M.P.H., project advisor for WRC/CSS Child Survival VII project, and A. M. Amin, M.D., who has extensive experience with Save the Children in Bangladesh. Table 5 below lists the technical support provided to the project thus far. Future needs for technical support were not well defined by field staff

Table 5
Technical Support Provided

Who Provided Technical Assistance	Type of Assistance Provided	Dates
International workshop in Bangalore, Karnataka, India	Training, networking	October 2-7, 1994

ICDDR,B	Project staff discussed and were advised on recent developments in ORT	February 18, 1995
Syeda Aleya Nayeem, nutritionist from Helen Keller International	Assisted in developing action plans for CSP Vitamin A component	February 20, 1995
ICDDRB, Asia Foundation, Helen Keller, Bangladesh National Nutrition Council	Seminar on data collection for DIPs	March 19-22, 1995
World Vision in Khulna	One-day workshop on sustainability of project goals	April 4, 1995
Save the Children Child Survival Project in Nasirnagar	Key WRC staff observed CSP management, monitoring system and other activities	April 26-May 8, 1995
JHU CSSP	KPC Training of Survey Trainers (TOST) in Kathmandu, Nepal	May 30-June 8, 1995
Dr. Muriel Elmer from WRC HQ	Assisted with baseline surveys, writing DIP, quarterly reports, provided regular advice through fax, phone and sending Hearth training materials and other technical materials	Ongoing

Lisa Filoramo, MSPH., Nutrition Consultant from WRC HQ	Worked in Bangladesh as Nutrition Trainer with Shishu Kabar. Provided technical backstopping in the following areas: a. Training CSP union officers, supervisors and interviewers in conducting baseline survey b. Coordinating the baseline survey c. Conducting focus groups in preparation for DIP d. Writing DIP and training curriculum for GMC and Hearth e. Assisting CSP staff in GMC training f. Assisting in formulating response to DIP technical review g. Providing technical help in development of Vitamin A curriculum h. Technical backstopping in design of Hearth training materials and supervision of SK Project i. Providing technical help in writing first annual report, maternal care and family planning curriculum and other resource materials	February-November 1995
Arne Bergstrom, WRC Asia Regional Director	Discussed management issues with Dr. Mostafizur, interviewed candidates for health educator position, discussed management and implementation issues for the Hearth (SK) Program with Lisa Filoramo (Nutrition Trainer from WRC HQ)	March 16-22, 1995
Arne Bergstrom	Advised CSS on management issues as CSS Director Dr. Paul Munshi was replaced by son, Mark Munshi; Discussed sustainability strategies and long-range planning for CSS and the CS Project	October 18-24, 1995
Sylvia Rhodes, USAID Project Officer	Evaluation	May 22-24, 1995
Olga Wollinka, WRC HQ Gretchen Berggren, MD Gordon Buhler, PhD	Midterm Evaluation, Hearth evaluation, USAID visit	May 8-19, 1996
A.M. Amin, MD	Retained for technical assistance as needed (i.e., HIS revision, training, etc.)	Ongoing
Fazlur Rahim, MPH	Retained for technical assistance as needed (Pre-MTE CSP evaluation, etc.)	Ongoing
Eric Star-buck, PhD USAID BHR/PVC	USAJD visit, ALRI consultation, visit to HEARTH sites	July 26-27, 1996

Lisa Filoramo, MSPH	Implemented the HEARTH evaluation plan	July 23--Aug. 9, 1996
Ken Graber, Microenterprise Director, WRC HO	Assistance in the Income Generation component of the program.	Sept. 19-26, 1996

IV.J Assessment of Counterpart Relationships

The chief counterparts to this project are the Thana Health Centers in Paikgacha and Koyra and their outreach workers, the health assistants (HA), family welfare assistants (FWA) and family welfare visitors (FWV). EPI activities are done by the HA and FP, and maternal health work is done by the family welfare workers. In each case project staff promote these services, monitor coverage and coordinate their growth monitoring (GM) and nutrition education sessions with the government assembly posts. Medical referrals of high-risk pregnancies or malnourished children who fail to respond to rehabilitation are potentially important complementary roles for project workers.

There appears to be a lot of goodwill between government officials and the project, but communication to the MCH officer of such details as where project-trained TBAs are active or reporting project HIS data to appropriate government offices is less regular than could be expected. Government facilities for referral are very basic, For example, an obstetrical emergency in Koyra is at least 6 to 8 hours from Khulna, the nearest facility equipped to do a cesarian section. An excerpt from Dr. Gretchen Berggren's notes on her visits to counterpart government offices illustrates the quality of these relationships:

> The Office of the Civil Surgeon welcomed us as World Relief/CSS representatives. Although the civil surgeon deputy director was preoccupied with procurement and appropriate administration of rabies vaccine due to some dog bites in the area, he took time out to assure us that CSS has been most helpful to government in bringing about needed child survival activities. He said, "Unless special resources are found, we often cannot accomplish our mandate. We have the infrastructure; we need PVOs for social mobilization and to get the appropriate back-up activities flowing. CSS has been exemplary.
>
> Government officials seemed to see the SK simply as a 'feeding program' in several interviews. They did not understand that the project begins by identifying the feeding behaviors of the families with well-nourished children, and thus can build on the traditional wisdom of the people. The MCH officer for Koyra assumed that CSS was distributing a supplementary food in feeding stations in its SK sessions. They also needed reassurance that if the CS program distributes growth charts, they are those already approved by the MOH of Bangladesh.

At the Thana level, the reception at Paikgacha Thana Health and Family Planning Complex was very warm. Dr. Arabinda assured us that CSS brought welcome and needed innovation at the grass-roots level, had enhanced and expanded government capability and worked closely with his people. He said, "I have offered training and helped to train CSS workers. I only wish they were in every union under my jurisdiction!" Perception of the Hearth (SK) program was not that it was an educational program for mothers of malnourished children. with a more detailed explanation, Dr. Arabmda was most enthusiastic. Although he is a trained surgeon, Dr. Arabmda cannot carry out caesarian sections or perform other interventions for obstetrical emergencies. Ruptured ectopic pregnancies, placenta abruptio and other obstetric emergency cases would likely die before reaching a facility where they might be helped. Dr. Arabmda showed us a small and very inadequate pressure-cooker sterilizer, the only thing he has with which to sterilize instruments. No suction apparatus is available, although he does have electricity. Bottom line: Referral time for obstetrical emergencies: 2 - 3 hours to Khulna.

The reception was somewhat more guarded at the Koyra Thana level. The newly arrived doctor in charge complained that he is an hour away from a telephone, and when he gets to the office where he could telephone, he often finds it locked. There is no electricity at the hospital and no autoclave, and yet young surgeons have been assigned there. Here obstetrical emergencies cannot be dealt with; women are referred by boat to Paikgacha (above) and then must go by ambulance to Khulna. Bottom line: Referral time for obstetrical emergencies: 6 - 8 hours to Khulna.

The MCH officer assigned to Koyra lives in Khulna but visits Koyra on some days. His concern was that CSS had trained TBAs, and he had not been given their names, addresses, nor copies of the high-risk pregnancies they detect.

IV.K Referral Relationships

Section IV.J describes the referral situation in general. The team discussed with project management the possibilities of establishing a more active referral relationship, particularly for obstetric cases and possible tuberculosis cases among malnourished children. As the project initiates the ALRI intervention more definite lines of referral will need to be established and greater efforts at communication will need to be made. At present some HAs have supplies of antibiotics and are trained to recognize acute cases for referral. They give one dose of antibiotic to begin treatment and give the child time to reach a referral center. However these HAs cover relatively large areas and are not immediately accessible to a family with a child who becomes acutely ill at night. It will require close coordination with government services to enable project CHWs to extend this kind of access to the neighborhoods where they live. Since CHWs care for only about 250 families they can be more readily accessible in cases of acute illness, and if trained and supplied with stopwatches and antibiotics, could provide urgent care to children with pneumonia.

IV.L PVO/NGO Networking

CSS is a member of the Voluntary Health Services Society (VHSS) of Bangladesh and regularly sends representatives to this meeting. In addition, CSS has excellent relationships with other PVOs in the Khulna area, and in fact has helped to initiate PVO meetings. In Khulna area organizations and individuals who might **be** interested have been invited by CSS to local PVO meetings.

Members of the evaluation team met with organizations which have local projects. These conversations suggested that CSS is highly regarded, and has been a leader in the movement for PVOs to get together for the purpose of coordination and resource sharing. Underprivileged Children's Education Project (UCEP) seeks help from World Relief for resource sharing as it provides education to underprivileged children so that they can compete in the workplace. FPAB (Family Planning Assistance Bangladesh) has worked in close collaboration through its Khulna office as has BANOFUL, a local NGO interested in health of women and children. In April 1995 CSS was asked to organize and implement a workshop on AIDS/HIV prevention for all the PVOs in the Khulna region.

IV.M Budget Management

Expenditures to date compare well with the project budget (see pipeline analysis). The project is on course to achieve objectives with the remaining funds and it is not likely that the budget will be substantially underspent. Project accounting is done by a professionally trained CSS accountant.

V. Sustainability

CSS has established a presence in Paikgacha constructing a fine hospital building which will be equipped and staffed to treat eye diseases and, we recommend, provide a much needed emergency obstetrical service. This hospital and the CSS center for poverty lending which it houses can become a strong base for continuing CS activities in the area. Table 6 below summarizes the project's steps toward sustainability.

Table 6

Sustainability Goals, Objectives, Midterm Measures and Steps Taken/Needed

End of Project Objectives	Steps Taken to Date	Midterm Measure	Steps Needed
1. Change in mothers' knowledge and practice as indicated by final KPC survey	See Sections I and II for description of outputs to date and progress toward K & P objectives	CHW register, bimonthly reports and qualitative interviews	continued educational efforts particularly in TT2 promotion and growth monitoring
2. CSS will be capable of implementing CS programs and attracting other funds to support CS initiatives after AID funding, as indicated by increases in CSS budget.	CSS has followed the previous CS project with continued CS activities funded by Word and Deed, a PVO based in Holland. CSS has also obtained funding from Cristofel Blinden Mission to build an eye hospital in Khulna.	Donor contributions	Continued fund-raising and grant writing efforts
3. Community demand for MOHF'P services will increase as indicated by coverage of services provided by MOHFP at the end of project.	CSS/CS project has actively promoted immunization and child spacing, meeting coverage objectives for year two by the midterm (see Section II).	CHW reports on coverage	Continued promotion of MOHPP services, particularly tetanus vaccination and maternal care
4. Community resources will be increased as indicated by CHWs and TBAs trained.	103 CHWs trained and active by midterm; 103 TBAs trained by midterm, exceeding objectives in both categories (see Section 1V.D).	Training records and supervisors' reports on community activities	Continued training and upgrading of these workers (see Section VI for recommendations for TBA selection and training)
5. Cost recovery income generated from Ladies Savings and Loan Society and animal husbandry cooperatives will help pay cost of CS activities after AID funding ends.	To April 1996 a total of 2,100,000 taka had been loaned yielding 80,000 taka in interest. Most of the money had only recently been lent so interest payments will continue for some time.	Loan accounts	Increase loan funding and develop a plan to use interest income for specified activities (i.e. funding of the SK trainers and Maternal Health Trainers)
6. Mothers will be able to provide better nutrition for families as indicated by percent of mothers with malnourished children participating in the loan and animal husbandry programs.	Data on this indicator are not precise, however ability to provide better nutrition is indicated by achievements of the SK program described in Section II.	Response to nutrition demonstration rehabilitation program	Track loan participation among mothers completing the SK Program

VI. Recommendations

1. **Effectiveness-Growth Monitoring:** Increase attendance at growth monitoring/counseling (GMC) sessions to achieve or exceed 70% coverage, the end of project objective. Suggested approaches:

   * Do a mini survey of non-attenders to discover why mothers are absenting themselves and design messages to overcome these barriers.

   * Educate fathers and mothers-in-law on importance of GMC.

   * Explore use of new UNICEF digital read-out scale where mothers hold babies so they do not cry and thus mothers are less put off by the weighing process.

   * Add new dimension to assembly post activities by offering some simple treatments such as use of dilute gentian violet or antibiotic ointment for small open skin lesions.

   * Upgrade CHWs' role in GMC sessions to that of completing the growth chart and bring in volunteer mothers from the SK program to assist in weighing children. (These workers live in the community and are more apt to be a "sustainable" element in the future.)

   * Do an extra weighing just before the Hearth (SK) session and make every effort to weigh every child under the age of two. Since SKs are very popular, let it be known that one is about to begin and that all children under the age of two are eligible provided mothers bring them for weighing. It is more likely that all the children would be brought for weighing on the eve of the SK.

2. **Effectiveness-Nutrition demonstration/rehabilitation (Shishu Kabar):**

   * Educate and recognize the husbands who will be purchasing the SK food in at least one education session prior to the SK session. Recognize that in Bangladesh, the volunteer mother by definition must involve her husband since he does the shopping, therefore he must understand the importance of what he is doing. If he buys too little, or downgrades the menu, children will not benefit as they should.

   * Repeat SK sessions in villages where the first rotation was done after weighing fewer than 70% of under-twos in the community. Plan to have a second rotation where the number of malnourished children in a community is more than 35, giving priority in the first session to the most severely malnourished and those between 18 and 23 months.

3. **Effectiveness-Tetanus immunization:** Priority should be given to social mobilization for tetanus immunization of all women according to MOH policy of "five doses for lifetime immunity." Possible innovations to achieve 80% coverage by EOP:

   * Give special prizes at immunization and growth monitoring/counseling sessions to mothers who have their own immunization updated and bring a woman friend as well.

   * Take advantage of "missed opportunities" such as government National Immunization Day to add manpower to give tetanus toxoid to all mothers who bring their children to this special event.

   * Work closely with EPI personnel to conduct a mass campaign for TT vaccination.

4. **Effectiveness-Women's health:** Iron and folate distribution should be ensured at Family Welfare assembly posts and wherever antenatal care is provided. This will need to be done in close collaboration with the family welfare assistant and the MCH officer at the Thana level.

5. **Management and use of data:** The complex and informative data base which this project has collected should be used to communicate more effectively with counterpart government staff and members of the communities in which it originated. Specifically we recommend that:

   * Local Thana and Union health services officials be provided with a list of active CSS personnel in the communities under their respective jurisdictions. This is particularly important for TBAs, but also for supervisors, CHWs, and SK workers and is a first step in creating collaborative linkages at each level.

   * Births and deaths noted by CSS personnel be promptly reported to the appropriate government counterpart or higher level official responsible for maintaining vital events data (the health assistant or health inspector).

   * TBAs trained by the project report births and high-risk pregnancies to the nearest MCH officer at the Thana Health Complex.

   * Data for each community be summarized and presented to mothers group meetings on a regular basis to inform them of progress and problems and seek their participation in problem solving. This will need to be presented in a form which is readily understood by illiterate members of the community, for example use of pie charts to illustrate proportion of women not yet immunized. Training in this form of communication is necessary.

* More attention be focused in future child survival project design on developing information systems which mesh with government reporting systems. The information system, if designed with sustainability in mind, can be the nexus of PVO/government collaboration and become one of the most sustainable improvements left behind at the end of project.

* CHW registers be checked in a consistent and truly random way to be sure that the register accurately reflects the home-based records. Likewise, supervisors' reports be checked against CHW registers on a random basis and whenever there appears to be reason to verify their accuracy. Supervisors and union officers will need to be trained in Lot Quality Assessment Sampling (LQAS) methodology to conduct this type of assessment.

6. **Human resources for child survival:** There is some evidence that TBAs were not chosen as planned (that is, that they should be identified by the community as already active). We recommend that :

* Untrained TBAs active in the project area be identified through asking the CHWs to report births by name of attendant and identifying them as trained or untrained. Those most active among the untrained TBAs should be identified and reported to the Ministry of Health officer in charge of TBA training/reporting system. In concert with the MOH officer, another training should be planned.

* Names and addresses of TBAs trained should be reported to the government MCH officer who is in charge of TBA training. He should be informed also of the curriculum used and who carried out the training.

7. **Supplies and materials for local** staff: Expendable supplies in TBA training kits must be replaced or renewed regularly.

* Small, sterilizable "clean-cord-cut packets" are better than balls of string and cotton kept loose and getting dirty in their kits as we observed. "Clean-cord-cut" small packets (old newspaper can be used to make the packets), can be opened at the moment of delivery, each containing a sterile or very clean razor blade, two pieces of string to tie the cord, and sterile gauze to use as a dressing.

8. **Supervision and monitoring:** Current supervision is provided through vertical "chains of command." For CHWs (all women) this involves the supervisor, union officer, area coordinator, and project director (all male). For TBAs there are two nurse-midwife trainers who report to the area coordinator, and for SK volunteer mothers there are five SK trainers who report to the SK program coordinator, who in turn reports to the project director. The team recommends that, to enhance sustainability, this organizational structure be made "leaner" and focus on women helping women. Specifically we recommend that:

* The nurse midwife trainers and SK trainers work very closely with government family welfare assistants and family welfare visitors to connect the volunteer mothers to these government workers, thus ensuring a supervisory support system for volunteers beyond the life of the project.

* If funding is to be continued at a reduced level after the end of project, it be used first to support the SK trainers and nurse midwife trainers who will have developed a network of women volunteers in the communities.

* Greater emphasis be placed on encouraging and supporting CHWs while continuing to press for quality improvement.

* Consideration be given to reducing the number of field supervisory personnel during the second half of the project and placing more responsibility on the CHWs for such things as nutrition counseling at GM sessions and holding mothers group meetings.

9. Referral Relationships: A primary responsibility of the physician is to understand and maintain the best possible integration with the programs of the Ministry of Health in the area. He should assist Thana health officers and collaborate with other NGOs in any way possible to bring emergency obstetrical intervention to the Thana level and otherwise facilitate referral relationships for medical care. Specifically:

* In Khulna, explore possibilities for reducing MATERNAL, MORTALITY with MOH authorities and other PVOs. Explore possible resources with World Vision and others who maintain health clinics, to be sure that children get referred up the line to the best possible care even if they get referred all the way to Khulna.

* Explore with Thana government doctors and donors the possibility of equipping part of the new hospital in Paikgacha to develop caesarian section capability.

* Children who continue to suffer growth failure after attending nutrition SK rehabilitation/ education (Hearth) sessions must have special attention. This includes follow-up of children who are referred for treatment of any sort. Issues are:

  Identification of missing elements in the Thana health center level that could have saved the life of the child. This should be discussed with the civil surgeon or those directly under him. For example, CARE has had good experience in getting better health care to its impact areas simply by diplomatic reporting of problems occurring when ill children from their projects received inadequate or inappropriate treatment.

  Ruling out TB as a cause of growth failure when other causes are not found. According to the civil surgeon in Khulna, a CSS doctor could be supplied with Mantoux or PPD testing materials provided he understands and can demonstrate that he can be a trainer for PPD testing. Although children have had BCG and will normally have mild PPD reactions, reactions of 10mm or

more or blister reactions should still get the child referred for x-ray and pediatric evaluation.

VIL Summary

This midterm evaluation was done by a team consisting of Gordon Buhler Ph.D., M.P.H. (an independent consultant and team leader), Gretchen Berggren M.D., M. Sc. (of Albert Schweitzer Hospital in Haiti), Mohammed Fazlur Rahim, M.P.H., (former project director for WRC/CSS in Botiagatha, Bangladesh) and Olga Wollinka M.S.H.S.E. (WRC headquarters representative). The team was on-site from May 8-20. Gordon Buhler is the principal author of the report, however substantial portions were drafted by other team members (see Appendix C worksheet).

USAID Guidelines were reviewed and sources of information that would enable the team to respond were identified. Assignments for interviewing and reviewing documents were made and logistics outlined. (Please see Appendix C for an outline of the methods used.) Interviews were done with project staff at all levels; MOH personnel at the district, Thana, and outreach levels; TBAs, mothers and community leaders.

During the 20 months the project has been in operation WRC/CSS has hired, trained and fielded a qualified staff including 103 CHWs who live in the communities they serve. A comprehensive, census based HIS using household registers maintained by the CHWs has been developed, and the staff has learned to use it for monitoring coverage of EPI services, Vitamin A distribution, contraceptive use and antenatal care, all services provided primarily by government workers. In addition the project does growth monitoring and an innovative nutrition demonstration and rehabilitation program patterned after the Hearth program pioneered by Drs. Warren and Gretchen Berggren in Haiti and their associates in Vietnam.

Outcome measures are based on the HIS service records which show excellent immunization coverage (95%) among the under-one population, Vitamin A coverage among the 12 to 71 month group reached 91% and growth monitoring 62%, just over the year 2 target of 60%. Contraception use is reported by 57% of registered eligible couples, well in excess of the 40% target.

TT2 immunizations for CBA women was perhaps the most difficult objective to achieve. Almost 50% coverage was reported whereas the target for year 2 is 70%. Greater awareness of the need for all women to be vaccinated rather than just those who are pregnant and recognition that more than two vaccinations are needed to generate lifetime immunity needs to be developed among project staff and then the community.

Perhaps the principal lesson learned has to do with the necessity for close collaboration with government services and the need to share information with the local health team. This requires active leadership that is well connected to the local government and medical systems. It also requires that the information system be designed to interdigitate with the government's system. Additional information to meet USAID requirements or the PVO's interests may be very valuable, but sustainability of a very complex system that goes well beyond anything the government is able

to do is questionable. In the area of this project where registration of vital events such as births and deaths is far from complete, it seems most appropriate that a CS project devote a good deal of its information gathering abilities to strengthening that system.

Other key recommendations include developing stronger referral and reporting contacts' project-trained TBAs and the Thana and Union MCH officers. TBA kits need to be made more nearly sterile. At present string, blades, forceps, cotton and towels are all kept in a bag to be boiled when needed. We recommend that the TBAs be supplied with packaged, sterilized blades and cords. These can be prepared and sterilized at the CSS hospital in Khulna.

The project is very much on track in meeting its targets for the midterm. WRC has committed to continued funding at a more basic level beyond the end of project. The last half of the project cycle provides opportunity to develop closer ties to the local system and strengthen it at the community level.

APPENDICES

A PERSONS AND GROUPS INTERVIEWED

B GRETCHEN BERGGREN'S REPORT ON SHISHU KABAR

C EVALUATION PROCESS PLANNING DOCUMENTS
EVALUATION TEAM SCHEDULE
INTERVIEW GUIDE

D CHRISTIAN SERVICE SOCIETY ORGANIZATIONAL CHART

E PIPELINES

APPENDIX A

PERSONS AND GROUPS INTERVIEWED

Mr. M. Amanullah, Divisional Coordinator, Under-Privileged Children's Education Project

Dr. Dayal, Project Manager, World Vision

Dr. Jubayer Hussain, Project Manager, CAKE

Area Coordinator for Khulna and surrounding area, CARJTAS

Government Officials: The Civil Surgeon's Office, Deputy Director

Dr. Arabinda Kumar Dey, Paikgacha Health Complex

Dr. Mustafan Oder, Koyra Health Center

Dr. Mash Ulaban, Maternal Child Health Officer for Koyra

Community Mothers

CSS Project Physician

Health Educator

Supervisors

CHWs

TBAs

APPENDIX B

SPECIAL REPORT ON SHISHU KABAR PROGRAM
BY GRETCHEN BERGGREN, M.D., M.Sc.Hyg.

I. Benefits of the HEARTH project to the overall Child Survival Program

II. Training emphasis

III. Problems associated with the objective

IV. The menus and the quantity of calories

V. Liaison with MCH program of MOH of Bangladesh

VI. Summary of special problems and recommendations for the SK project in Bangladesh

VII. Results

VIII. Feedback on Results/Recommendations from the Khulna team

L Benefits of adding HEARTH program to a Child Survival Project

Interviews with mothers and community health workers revealed that HEARTHs had added a dimension of goodwill to the project, and that it was appreciated by the people. Remarks from leaders translated to me included,"Now we see that CSS really means to do something to help our mothers!" and "Now we understand why CSS workers need to weigh our children and graph the weights." And from the mothers came remarks such as, "Now my child plays more, is hungry, and more active. I saw this happen while he/she was fed extra food at the HEARTH program." Some children entered the HEARTH having lost the ability to walk due to marasmus; by the end of two weeks the child had learned to walk again. Everyone was impressed, especially because this improvement could not be attributed to medications but rather to food alone; food locally available and inexpensive.

Growth monitoring/counseling is often misunderstood by parents who see that the child cries during the process and upsets the mother does not really understand why she must now try to focus on the growth chart. These mothers do not see any immediate benefit, especially if the message is "Feed the child more" while her chief complaint is "My child will not eat."

One mother we observed was delighted with the HEARTH but could not yet "see" that the line on the growth chart that meant her child was improving. But now she could see that her child became so hungry that he tried to put his face in the plate and gobble up the food before she could feed it to him bite by bite. It had become apparent to the mothers that the invitation to the HEARTH sessions had something to with what the growth chart was revealing, that it was related to food intake, and that this food was within their means since the menu was based on prior study of local women. Therefore the weighing and charting, and the many words spoken to her about food began to make some kind of sense. This creates interest in the village about the program, CSS, and about feeding children.

Interviews with mothers revealed that when the baby had lost weight, there had often been an associated infection. This and the anorexia noted by the mother was explanation enough about why the child was not doing well. Without the HEARTH session, it was less clear to the mother what she could do about this.

IL Training Emphasis

While the "three basic food groups" must be taught to the trainers, this message does not address the main underlying cause of malnutrition in Bangladesh. Therefore in the future even more time must be spent of three issues, that children under five need:

1) to eat more often (at least five times per day)
2) greater quantities of food than usual (almost as much as their father)
3) food made "richer" (more calorie dense) with oil

Over-emphasis on three basic food groups causes the volunteer mothers and the trainers to be less concerned about how much the child eats and too concerned that all food groups are represented in the menu.[3] Bangladesh mothers who get three or four snacks per day into their children should **not** be made to feel guilty if "three food groups" are not represented every time the child eats.

IIL Problems associated with the Shishu Kabar objective as stated in the DIP:

The evaluation team concluded that the objective is being reached. However, in every community there are malnourished children eligible for rehabilitation who have not yet been weighed. In order to reach them all, the SK trainers will have to do a second rotation through the same village once these missing children are identified.

The objective states that by midterm, 50% of malnourished children will have been rehabilitated in HEARTHS (SK's). However, since indicators show that less than 50% of children are weighed (in keeping with the mid-term objective), then as much as half the malnutrition may not be detected in the first place. Finding the correct numerator and denominator in this instance presented a problem to the evaluation team. It was resolved as follows:

1) To date 1,038 children completed SK rehabilitation out of the 1,220 children identified as "eligible" for SK. Does this represent about half the malnourished under two's? The team estimated that there are an estimated 2,284 malnourished under-two's in entire population, assuming that unweighed children (55%) have the same nutrition status as those who have been weighed. Therefore the 1,038 rehabilitated is 45% of estimated malnourished children, very close to target of 50%.

IV. The menus and the calories consumed:

a) Do Peanuts work?

An important addition made to the menus was the use of crushed peanuts to increase both the protein and the calories offered to the child. This idea did not come from the "positive deviant" mothers whose children are well nourished in the same village, but seemed an acceptable way to enhance the diet. Is it working? According to Rabeya, the SK Coordinator, when asking mothers about changes in feeding behaviors after HEARTH, they rarely if ever say they adopted the crushed peanuts. But adding more cooking oil they do mention, and this is taught as well. Perhaps adding even more oil to the menu is more in keeping with what "positive deviant" mothers do and what the HEARTH mothers can be expected to learn and practice.

[3] Note that in America a peanut butter and jelly sandwich may constitute a snack or a meal, and this is not considered inappropriate ss long as fruits and vegetables are included in other meals or snacks.

b) Do children consume enough?

All SK trainers agree that the volume of food offered to the child on the first day of the HEARTH may be "too much," but that by the last week, the child consumes much more, "usually all the food" at one sitting.

Getting the volunteer mother to offer helpings big enough to contain 700 calories appeared to be a problem. We observed that often a small "first helping" is offered, so as not to overwhelm the child. In this case, then the volunteer mother must be sure to offer a second helping and to encourage the child to eat it. Sometimes, we were told, mothers take home the extra left over food with the promise that they will give it later to the child. There is a danger of course that an older child will eat the food, or that it will be used to replace the child's portion from the family pot.

In our observation of the SK session using the same menu, there was obvious variation in the quantity of food prepared and the ingredients from one SK to another. One volunteer mother was preparing an egg "kitchuri" with somewhat lower quantity per child (less eggs and less greens) than her neighbor in the same village. She stated that her husband purchases the food, and she is not in control of what he buys. However, her meal was tasty and well accepted by the children who ate it with gusto.

V. Liaison with the MCH Program of the Ministry of Health of the District

Government officials seemed to see the SK simply as a "feeding program" in several interviews. They did not understand that the project begins by identifying the feeding behaviors of the families with well-nourished children' and thus can build on the traditional wisdom of the people. The MCH officer for Koyra assumed that CSS was distributing a supplementary food in feeding stations in its SK sessions. He also needed reassurance that if the CS program distributes growth charts, these are the charts approved by the MOH of Bangladesh.

VI. Special constraints associated with the HEARTH (SK) program in Bangladesh:

A. Constraints identified are as follows:

1) The project is identifying only half the "eligibles" for the HEARTH program. Only about half the mothers of under two's are attending assembly posts offering growth monitoring/counseling, and health education. Those most likely to refuse are mothers of children having completed their immunizations (the older 12-23 month old) children.

Comment: Mothers are motivated to get children immunized; once that is complete, the growth monitoring counseling [GMC] sessions do not attract them.

2) Workers complain that mothers do not like the weighing scales, because the child cries. Grandmothers especially say that if the child cries during the weighing process that it makes the child lose weight. Mothers do not like the weighing scales; a better model is needed.

Recommendations:

1. Coverage

1.1 Make social mobilization for GMC a priority so that all under-two's are weighed. Grandmothers (Mothers-in-law) and fathers must be targeted so that the family supports the mother to get the child weighed.

1.2 Do an "extra weighing" just before the HEARTH (SK) session and make every effort to weigh every child under the age of two.
Since SKs are very popular, let it be known that one is about to begin and that all children under the age of two are eligible provided mothers bring them for weighing. It is more likely that all the children would be brought for weighing on the eve of the SK.

2. Role of adult males in the SK program
In Moslem areas, the husband of the volunteer mother must purchase the food and may not understand the value of his participation' thus being tempted to downgrade the menu.

Recommendation:

2.1 Educate and recognize the husbands or volunteer males who will be purchasing the SK food in at least one education session prior to the SK session.

3. "Ownership" of the SK program
Government MOH workers and communities may not "own" the SK
session as coming from their own traditional wisdom, rather seeing it as a "feeding program."

Recommendations:

3.1 Be sure volunteer mothers, their husbands and MOH officials and officers understand that the menu comes from the study that volunteer mothers did in their own neighborhoods.

3.2 Ask families benefitting from the SK to contribute some food or fuel daily as their "ticket" to entry into the program' in order to increase a sense of "ownership" of the program.

4. Use of a more culturally acceptable weighing instrument:

Recommendation:

4.1 Procure as soon as possible from UNICEF their new digital read-out weighing balance where the mother holds the baby while being weighed.

5. Timing of follow-up weighings:

5.1 Children rehabilitated should be reweighed after 1 month, 2 months, and 3 months and then integrated into the GMC sessions. The supervisor should be able to produce a list of all children rehabilitated with date/weight on these children in appropriate columns. These children will be followed at 6 months and one year at the very least.

VII. Results:

Results are summarized in Table 1. For the two unions where enough results are recorded, it appears that 40% or more of the children are experiencing "catch-up" growth, having gained 700 or more grams in a two-month period. Another 50% are experiencing "adequate" growth, defined as 200-600 grams in the two-month period. Only 3-7% of children experience growth failure.

Comments: Three unions have too many "pending weights" or missing values from which to draw conclusions. The "adequate growth" criteria is too low. It should be 400 rather than 200-600 grams for adequate growth. Actually "adequate" should mean "growing at least as fast as the international standard median wt./age." Community-wide results cannot yet be ascertained due to the fact that only about half the children are weighed. Since the program reaches only under-twos (in contrast to under-threes in Vietnam and under-fives in Haiti), comparing to other programs is difficult.

Table 1
Results of "Shishu Kabar" Program (CSS) Paikgacha Service Center Report (August 95-Present)

Union	Total malnourished <23 month old targeted	Total enrolled (percent of target)	Total weighed at l&2 months (percent ofthose enrolled)	Pending--not due for follow-up (percent of those enrolled)	Lost to follow-up or refused weighing (percent of those enrolled)	Results for those weighed * (percent of total weighed from Column 4)		
						Catch-up growth	Adequate growth	Growthfaihlre
Kapilmuni	249	225 (90.4)	166 (73.8)	35 (15.6)	24 (10.7)	(i.8)	74 (44.6)	11 (6.6)
Raruli	230	208 (90.4)	202 (97.1)	0	6 (2.9)	(5.6)	115 (56.9)	5 (2.5)
Data for the following Unions are inadequate until more follow-up weighing is done								
Amadi	320	251 (78.4)	179 (71.3)	(E.7)	30 (12.0)	75 (41.9)	96 (53.6)	8 (4.5)
Haridhali	187	167 (89.3)	94 (56.3)	38 (22.8)	35 (20.9)	70 (74.5)	20 (21.3)	4 (4.3)
Godiapur	234	187 (79.9)	128 (68.4)	29 (15.5)	30 (16.0)	35 (27.3)	83 (64.8)	10 (7.8)
TOTAL	1220	1038 (85.1)	769 (74.1)	144 (14.0)	125 (12.0)	343 (44.6)	388 (50.5)	38 (4.9)

COMMENT: The above table needs to be completed and all figures recalculated after the "pending" weights are complete and after a real effort has been made to recover values for parents who refuse to have their children weighed. Apparently the refusal has to do with mothers-in-law who feels that the baby cries when weighed and that this has an adverse effect on the child. In this case, just as stated in the DIP, it is imperative that education be done with fathers and grandmothers so that they will agree to weigh the child one more time.

** "Catch-up growth" is 700 or more grams gained in two-month period.
"Adequate growth" is 200-600 grams gained in two-month period.
"Growth failure" is less than 200 grams gained in two-month period.

HEARTH TABLE 2

SHISHU KABAR (HEARTH) FOLLOW-UP TO DATE MAY 1996:
REASONS FOR MISSING VALUES (N.B.: WEIGHINGS YET TO BE COMPLETED)

UNION	NOT AT HOME	REFUSED	PENDING	TOTAL MISSING
KAPILMuNI	8	16	35	59
RARULI	2	4	0	6
GODAIPUR	19	11	29	59
AMADI	16	14	42	72
HARIDHALI	12	23	38	73
TOTAL	57	68	144	269

HEARTH TABLE 3

NUMBERS & LOCALE OF CHILDREN REFERRED DUE TO GROWTH FAILURE
(to be completed by the supervisor and the project physician:)

UNION:	THANA HEALTHCENTER	RESULTS RX	FAILED	IMPROVED	DIED
KAPILMuNI	3	6			
GODAIPUR	4	7			
RARULI	3	4			
AMADI	8	4			
HARIDHALI	4	4			
TOTAL	22	25			

VIII. Feedback on Results

Notes from the final "feedback" session with the CS staff at Paikgacha, May 18,1996:
Final impressions: The Shishu Kabar (SK) supervisor and the SK trainers have worked hard, and demonstrated competency in their training skills since they received their training under Lisa Filoramo. Over 1,000 children and their mothers have benefitted from the program and it continues to operate in one community after another. The program is generally appreciated by both staff and community. It is popular with mothers, except for the fact that they do not like to see the children cry when they are weighed, and some are refusing the follow-up weighing, blaming that activity for the child's lack of appetite.

Problems discussed at the final debriefing along with notes on the "feedback" session:
1) There are too many missing values in the follow-up weighing (see Table). Staff felt that children who have been through the SK and not weighed exactly on the date of their "one month" or "two month" anniversary maybe shouldn't be weighed at another date. It was explained that by getting and graphing the weights by month since the SK, we may need to visually observe and compute the "two month" weight to the best of our abiity; in any case we need the "three month" and/or "four month" weights of these children. It was agreed to carry out special follow-up.

2) Volunteer mothers do not buy the food themselves for the SK exercise since marketing is done by men. This has meant that the volunteer mother is dependant on a man (usually a community volunteer also) who takes the money to buy for her. The team observed that this may create a problem; the menu is exactly followed in some instances. At the final debriefing it was stated that "in Bangladesh, it is not only a volunteer mother but a volunteer father who is involved. This father needs orientation to the project and in some cases more explanation".

3) Informal interviews with the mothers who benefitted from the SK revealed that they were more concerned with explaining the importance of food variety than in the number of meals/day or the quantity of food a baby needs daily. They tended to leave out the mention of "oil" as a needed ingredient. Staff agreed on the need to emphasize oil and quantity of food.

4) SK trainers agreed that they will have to make another "pass through" with the SK program in those communities where only about half the children were weighed to determine eligibility for the program. If there are "too many children" eligible, the target will be to rehabilitate those most in need.

5) Government health personnel do not yet understand the program and tend to think of it as a "feeding program." Especially the MCH officers assigned to each Thana health complex, have not always been informed about the SK. Doctors at referral centers were not aware that mothers carried growth charts and that their personnel now had an extra tool (at least for under-two's) if they would observe the growth chart, which also always carries the note that a child participated in an SK. The physician with the SK team must build the liaison to the government.

6) Staffagreed that the Volunteer Mother will always have a male "helper" who must buy the food; he will need orientation and education about the SK so that he will buy the quantities of food required. The health educator with the project, Mr. Dulal Shome, agreed that this could be accomplished.

7) Since mothers need a different instrument to weigh the children, the project will explore procuring at least 20 sets of scales to replace the old ones.

8) The SK team will weigh all SK children as close to the "one month follow-up" and "two month follow-up" as possible, noting the exact weight and date, even if it is late for the "one month" or "two month" anniversary. The record kept by the SK supervisor, with birth month/year and date/weight for all follow-up weighing will allow better conclusions. The SK supervisor agreed to renew efforts to find all children, and the male staff agreed to help convince families of the importance of the weighing.

APPENDIX C
EVALUATION PROCESS PLANNING DOCUMENTS

L CHILD SURVIVAL X MID-TERM EVALUATION
Planning Worksheet

L **Accomplishments**

Responsible for writing	Questions or issues to be addressed	Primary sources of info	Interviewer or reviewer
A o w	Copy logframe	DIP	
B. OW	Input status	HIS	OW/MR
C. GB	Table of Objectives/achievements	HIS	GB

IL **Effectiveness**

Responsible for writing	Questions or issues to be addressed	Primary sources of info	Interviewer or reviewer
GB	Extent of achievement, constraints	Team discussion	GB

IIL **Relevance to Development**

Responsible for writing	Questions or issues to be addressed	Primary sources of info	Interviewer or reviewer
GB	Relevance to development	Civil surgeon, THO, TNO, WV, Caritas	GB/MR/GrB/ OW/FR/Sub-center staff

Iv. Design and Imulementation

IV.A. Design

Responsible for writing	Questions or issues to be addressed	Primary sources of info	Interviewer or reviewer
GB	How is data collected and used for decision making. (general statement)	MR/HIS	GB et.al.

n **V.B Manageme t and Use of Data**

Responsible for writing	Questions or issues to be addressed	Primary sources of info	Interviewer or reviewer
GB	**See g'lines**	**stag CHWS to** PD	GB,GrB, o w
OW	How are lessons learned institutionalized in the PVO		

IV.C. Community Education and Social Promotion

Responsible for writing	Questions or issues to be addressed	Primary sources of info	Interviewer or reviewer
GrB OW	See guidelines p. 2	Health ed. SK coord. field staff	All team members

IV.D. Human Resources for Child Survival

Responsible for writing	Questions or issues to be addressed	Primary sources of info n
GB	Description of staffing	DIP & MR
OW,GrB	Roles of CHWs, Assessment of appropriateness of training	Field staff, SK Coordinator, Health Educator

Child Survival Training Program Summary, see Table 4, Section 1V.D. of report

Type/# Dates	Training Topics	Topic Hours	Training Methods for Topic

IV.E. Supplies and Materials for Local Staff

Responsible for writing	Questions or issues to be addressed	Primary sources of info	Interviewer or reviewer
OW	DIP p. 52 compared to descriptions bv field staff and observation	Field staff	Team

IV.F. Quality

Responsible for writing	Questions or issues to be addressed	Primary sources of info	Interviewer or reviewer
GrB	See g'lines, Input from team in wrap-up	field staff, mothers	Team

IV.G. Supervision and Monitoring

Responsible for writing	Questions or issues to be addressed	Primary sources of info	Interviewer or reviewer
o w	See g'lines. Is supervision adequate? What needs to improve?	Field staff HIS	Team

V.H. Regional and Headquarters Support

Responsible for writing	Questions or issues to be addressed	Primary sources of info	Interviewer or reviewer
GB	What HQ support given? Adequate? What's needed?		

IV.1 **PVO's Use of Technical Support**

Responsible for writing	Questions or issues to be addressed	Primary sources of info	Interviewer or reviewer
GB	What TA does staff want? TA to date? Sources? Future needs? Constraints?	Staff	GB & Team

IV.J. **Assessment of Counterpart Relationships**

Responsible for writing	Questions or issues to be addressed	Primary sources of info	Interviewer or reviewer
GB	See g'lines	CSS, govt. off, WRC mgmt.	GB

IV.K. Referral Relationships

Responsible for writing	Questions or issues to be addressed	Primary sources of info	Interviewer or reviewer
Gr.B	What relationships to subcenters and hosp.? How are they being strengthened?	Thana subcenters field staff	Team

LL. PVO/NGO Networking

Responsible for writing	Questions or issues to be addressed	Primary sources of info	Interviewer or reviewer
GB	Relationships? Duplication? Sharing?	PVOS	GB

V.M. Budget Management

Responsible for writing	Questions or issues to be addressed	Primary sources of info	Interviewer or reviewer
o w	see g'lines	accounts & pipeline	

V. Sustainability

Responsible for writing	Questions or issues to be addressed	Primary sources of info	Interviewer or reviewer
GB	See g'lines for indicators.		Team

VL Recommendations

Responsible for writing	Questions or issues to be addressed	Primary sources of info	Interviewer or reviewer
GB	As observed by team members		

/II. Summary

Responsible for writing	Questions or issues to be addressed	Primary sources of info	Interviewer or reviewer
GB	method, project outcomes, quality, key recs.	Team	
o w	Costs, team composition, time		

II. EVALUATION TEAM SCHEDULE

Team member	11/5 Sat.	12/5 Sun.	13/5 Mon.	14/5 Tue.	15/5 Wed.	1615 Thu.	17/5 Fri.	18/5 Sat.	1915 Sun.	2015 Mon.
Cordon	In Khulna	Kapilmuni -Nasirpur -Noakoti Haridhali -Rejapur Haridhali UO/sup./SK/CHW/TBA	Khulna Civil Surgeon World Vision, Caritas, Mark M. Bidhan	Paikgacha Thana Health Adm Thana Exec Officer Raruli Sub center staff	Amadi UO/sup./SK/CHW/TBAs/moms Subcenter staff	Review & Draft recommendations Write Missing pieces	Write Debrief css & Project staff	Writing	Travel to Dhaka Visit USAID	In Dhaka Write and visit WV
Qretchen	Gcdaipur UO/sup./SK/CHW/TBA/moms	In Khulna	Raruli Srikantapur UO/sup./SK/CHW/TBA/moms	Kapilmuni &Haridhali Subcenter Staff	Amadi UO/sup./SK/CHW/TBAs/moms Subcenter staff	Review & Draft recommendations Write Missing pieces	Write Debrief css & Project staff			
Olga	Godaipur UO/sup./SK/CHW/TBA/moms	In Khulna	Raruli Srikantapur UO/sup./SK/CHW/TBA/moms	Paikgacha Thana Health Adm Thana Exec Officer Raruli Sub center staff	Amadi UO/sup./SK/CHW/TBAs/moms Subcenter staff	Review & Draft reeommendations Write Missing pieces	Write Debrief css & Project staff			
Rahim	Godaipur UO/sup./SK/CHW/TBA/moms	Kapilmuni Haridhali UO/sup./SK/CHW/TBA	Raruli Srikantapur UO/sup./SK/CHW/TBA/moms	OFF	OFF	OFF	OFF			
Mustafizur	Godaipur UO/sup./SK/CHW/TBA/moms	Kapilmuni Haridhali UO/sup./SK/CHW/TBA	Khulna Civil Sugeon World Vision, Caritas, Mark M. Bidhan	Kapilmuni &Haridhali Subcenter rtaff	Amadi UO/sup./SK/CHW/TBAs/moms Subcenter staff					

Interview Guide

Interviewer(s): G. Berggren, Olga Wollinka

Interviewee(s): Dulal, Rabeya

Date:

Questions: From sections IVC,D,E,I, IV C

1. How were messages developed, tested and refined?
2. How do you ensure that messages to community members are consistent?
3. Describe development, pretesting and distribution of printed materials, if any.
4. Describe how community education is done in this project.
5. How are nontraditional or participatory activities used? How has the project assessed the level of learning that has occurred with these methods?

IVD
Please see the last two paragraphs and table in Section IV D.

IVE
Please see IV E and the list of supplies and material on p.52 of the DIP. Ask these people about training supplies, educational materials, and any materials related to the hearth program.

IV1
Question #1 and #4 of guidelines Section IV I.

V
Applicable sustainability indicators in the sustainability table.

Field Notes:

CHRISTIAN SERVICE SOCIETY ORGANIZATIONAL CHART